STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
PO Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 F (916) 574-8636 | www.rn.ca.gov

REHABILITATION/TREATMENT FORM

RN NAME: _____ RN #_____

The probationary nurse, named above, is serving a probation term with this Board. Please complete this form and return to the Board at the address listed above.

The evaluator shall not have a financial relationship, personal relationship, or business relationship with the licensee within the last five years. The evaluator shall provide an objective, unbiased, and independent evaluation.

1. Date of entry into program: _____ Date of program completion: _____

2. Description of the rehabilitation plan/program:

☐ Inpatient ☐ Outpatient ☐ Counseling ☐ Drug Screening ☐ Aftercare

3. Is this nurse compliant with your program? ☐ Yes ☐ No

4. Once the program has been completed what is the recommended number of support groups the nurse should attend each week? _____

Comments: _____

_____

_____

_____

Name of Treatment Facility: _____

Address of Facility: _____

Facility Phone #: _____

Your Name:_____ Your Title: _____

Signature: _____ Date: _____